

Payment for Inpatient Hospital

The State of New Hampshire shall make payment for inpatient hospital services as follows:

1. The Diagnosis Related Group (DRG) method of payment as defined by the Medicare DRG prospective payment method shall be used for all inpatient hospital services.
2. The DRG relative weights shall be based on the Health Care Financing Administration (HCFA) weights published annually or periodically for Medicare in accordance with the requirements of 42 CFR 412.60, except New Hampshire relative weights will be used as specified in 3.a.(2).
3. Reimbursement shall be based on rates and amounts established by the Office of Medical Services, in accordance with the following methodology:
 - a. Normal hospital operating costs shall be recognized and paid on a per discharge basis and these payments shall be considered payment in full for such operating costs. Except where specifically noted otherwise, such payments shall apply to all hospitals - in-state, border and out-of-state.
 - (1) Inpatient acute care services shall be paid a predetermined price (in relation to a DRG with a relative weight equal to one (see 3.c. for calculation)) associated with the DRG assigned by the Division of Human Services, Office of Medical Services, to each Medicaid hospital discharge and this rate shall be uniformly applied, except as specified in (2), (3) and (4) below.
 - (2) For in-state hospitals only, inpatient psychiatric care services shall be paid a predetermined price associated with the psychiatric DRG (DRGs 425 through 432) assigned to each Medicaid discharge, but the price shall differ by the peer group in which the facility is placed, as follows:
 - (a) Designated Receiving Facilities (DRF) in Medicare certified Distinct Part Units (DPUs) shall be paid a per DRG average peer group rate, phased in over three years. Beginning January 1, 1989 the rate shall be comprised of 50% of the peer group average and 50% of the hospital specific cost. Beginning October 1, 1990 the rate shall be 75% and 25% respectively. Beginning October 1, 1991 the rate shall be the peer group average.

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- (b) Medicare certified DPUs without DRGs shall be paid a per DRG average peer group rate.
- (c) Psychiatric services provided in a medical/surgical setting (scatter beds) shall be paid a per DRG average rate based on the average cost per psychiatric DRG across such facilities.
- (d) Governmental psychiatric hospitals shall be paid per diem rates for inpatient acute psychiatric services. The per diem rate shall be set using the approved budget and the projected number of patient days for the fiscal year to which the rate is to apply.

The budgeted costs for the support areas are allocated to the patient care units using the Medicare step-down methodology and the statistics from the most recently submitted Medicare cost report. The cost for each support area is divided by the total statistic to develop a unit cost multiplier. This unit cost multiplier is then applied to the statistic for each unit to allocate cost. The support units are stepped down following the Medicare sequence, starting with Capital Related Costs, then Administration, Maintenance, Operations, Laundry, Housekeeping, Dietary, Nursing Administration, Pharmacy, and Medical Records.

The total cost of each direct care unit is then divided by the projected number of patient days. The number of patient days is projected at 90% of the available patient days.

- (3) For in-state hospitals only, inpatient (physical) rehabilitative Medicaid discharges in Medicare certified DPUs or rehabilitation hospitals shall be paid only a flat rate (with no additional outlier payments) for the one rehabilitation DRG (DRG 462). The rate represents an average cost across such facilities.
 - (4) Neonatal care for Medicaid discharges assigned certain DRGs (DRGs 385 through 390) shall be paid only a per diem rate (with no additional outlier payments) associated with the specific DRG. The rate shall be paid at 65% of the full per diem amount.
- b. Certain costs over and above normal hospital operating costs shall be recognized and paid in addition to the DRG payments made under 3.a. above. These payments shall be made as pass-throughs to individual hospitals or in the form of payments for day outlier cases added to the discharge (DRG) payment. Except where specifically noted otherwise, such payments shall apply to all hospitals - in-state, border and out-of-state.
- (1) For in-state hospitals only, capital costs, direct medical education and non-physician anesthetists costs shall be paid at a rate proportional to the Medicaid share, as calculated using Medicare principles (see 4 below), of actual hospital-specific costs. Such payments shall be made quarterly.
 - (2) Day outliers shall be paid (except as specified in 3.a.(3) and (4)) for all DRGs for all facilities on a per diem basis, at 60% of the calculated per diem amount (see 3.d. for calculation), and outlier payments shall be added to the DRG payments. Payment shall be made for medically necessary days in excess of the trim point associated with a given DRG. Medicare trim points shall be used except where New Hampshire specific trim points have been established.
 - (3) The Medicare deductible amount for patients who are Medicare/Medicaid (dually) eligible shall be recognized and paid.

- (4) For only in-state hospitals with approved graduate medical education programs, indirect medical education costs shall be recognized and paid on a per discharge basis, using the Medicare methodology in 42 CFR 412.118 to determine the amount of payment. Such payments shall be added to the DRG payment.
- (5) There shall be a reserve "catastrophic" fund equal to seven percent of the projected gross annual Medicaid inpatient hospital expense. This fund shall be used to provide for payments for inpatient hospital services outside the DRG system where the DRG payment plus third party liability is below 46% of charges, and the hospital requests additional funding. Hospitals must request additional payment under the Catastrophic Fund based upon any of the following criteria:
 - a. Financial need of the hospital in order to continue to serve current patients and/or future Medicaid patients;
 - b. Extraordinarily high costs due to the severity of the case, and
 - c. Lengthy stays meaning in excess of 30 days.

Reimbursement for each request shall be limited to 65% of charges reduced by prior payments, DRG allowed amounts and third party liabilities. Requests shall be considered on a first in, first paid basis until the fund is depleted. Requests not paid in any year shall be carried forward to the next year. The percent of charges reimbursed shall be adjusted below 65% for each year unpaid requests are carried forward in order to not exceed 7% of the projected inpatient hospital expense for the year.
- c. The calculation for the price for a DRG with a relative weight equal to one (1.0000), to be used for all DRGs except those specified above for psychiatric, rehabilitation and neonatal services, shall be as follows:
 - (1) Reduce the DRG price per point by 5.003 percent effective October 1, 1995 through June 30, 1996, and effective July 1, 1996 revise the DRG price per point reduction to 5.067 percent through September 30, 1997.
 - (2) Beginning October 1, 1997, and each year thereafter, take the current DRG price per point(s) and inflate each by the same percent as the Medicare market basket estimated increase for prospective payment hospitals minus any Medicare budget neutrality factors and other generally applied Medicare adjustments appropriate to Medicaid.

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- d. Other relevant calculations: The price per DRG (unless otherwise specified) shall be calculated by multiplying the relative weight for that DRG by the price for a DRG with a relative weight equal to one (1.0000). The per diem price associated with a given DRG shall be calculated by dividing the price for that DRG by the geometric mean length of stay associated with a given DRG(s). The price for a day outlier shall be the per diem amount times a percentage factor, currently 60%. The cost for outlier payments associated with a given DRG(s) shall be calculated by multiplying the day outlier price by the number of outlier days for that DRG.
4. Capital costs, and direct medical education costs shall be allowed as pass-through payments in accordance with OMS guidelines. OMS guidelines shall be based on the Medicare guidelines established in 42 CFR 412.2 for capital, medical education and nonphysician anesthetists pass-throughs.
5. Day outliers shall be reimbursed on a per diem DRG payment. Cost outliers shall not be recognized nor reimbursed. (also, see 3.b.(2) and 3.3. for day outliers)
6. Periodic interim payments as made under the Medicare Program shall not be made by the Medicaid Program.
7. Pricing shall be prospective and payment shall be retrospective.
8. Payment rates shall be based on the relative weights and payment rates in effect at the time of discharge.
9. DRG payments shall be made for admissions occurring on or after January 1, 1989. Payment for admissions occurring prior to 01/01/89 shall be made in accordance with the rules in effect prior to 01/01/89.
10. Providers of hospital services shall make quarterly refunds of Medicaid payments that are in excess of the Medicaid allowed amounts.

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Disproportionate Share - Payment Adjustment

There are three methods of payment adjustment made for hospitals qualifying as disproportionate share hospitals.

The first type is a disproportionate share hospital which is a hospital (a) which has a Medicaid inpatient utilization rate (as defined in Section 1923(b)(1)(A)) that is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state, or (b) which has a low-income utilization rate (as defined in Section 1923(b)(1)(B)) exceeding 25 percent. Calculations are based on the state's most current data base and are updated yearly. Additionally, the hospital must have at least 2 obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the state Medicaid plan. The term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. The above obstetric-related criteria do not apply to hospitals in which the inpatients are predominantly individuals under 18 years of age, or to hospitals which do not offer non-emergency obstetric services as of December 31, 1987.

The payment adjustment is calculated as an amount equal to the product of the hospital's Medicaid operating cost payment (prospective payment amount, i.e. DRG plus outliers) times the hospital's Medicare disproportionate share adjustment percentage developed under rules established under Section 1886(d)(5)(F)(iv) of the Act, that can be paid to eligible hospitals. For out-of-state hospitals, the payment adjustment is paid according to that state's calculation.

An outlier payment adjustment will be made for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stays for infants who have not attained the age of 1 year, and to children who have not attained the age of six years. When and/or under what conditions this payment is made is as follows:

After thirty days of date of admission, the hospital notified the Medicaid Program regarding a pediatric case(s) which is resource intensive, requires a lengthy stay (in excess of the day outlier threshold or thirty days whichever is longer) and which the DRG rate of payment has been estimated to be less than 65% of charges.

The adjustment payment is the difference between the DRG payment plus normal day outlier payments and 65% of charges.

The payment adjustment will be phased in over a 3-year period. As of July 1, 1988, the adjustment will be one-third the amount of the full payment adjustment; as of July 1, 1989, the payment will be two-thirds of the full payment adjustment; as of July 1, 1990, the full payment adjustment will be made.

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Disproportionate Share - Payment Adjustment

The second type is a disproportionate share hospital which is a governmental psychiatric hospital in which 50% or more of service revenue is attributable to any combination of the following:

- public funds, excluding Medicare/Medicaid
- bad debts
- free care

Hospitals of this type shall receive payment equal to the cost of services furnished to Medicaid patients, less the amount paid under the non-DSH payment under this plan, plus the cost of services provided to patients who have no health insurance or source of third party payments, less the amount of payments made by these patients.

Additionally, hospitals of this type which, during December 1994, had a Medicaid utilization rate of at least one standard deviation above the mean Medicaid utilization rate in the State shall receive payment equal to the cost of services furnished to Medicaid patients, less the amount paid under the non-DSH payment under this plan, plus the cost of services provided to patients who have no health insurance or source of third party payments for services provided during the current State fiscal year, less the amount of payments made by these patients. This payment will be made based on the most current cost and revenue data for the year and shall be adjusted based on actual cost and revenue data following conclusion of the fiscal year.

The psychiatric hospital definition meets the exception under 1923(d)(2).

Outlier payments per Section 302(b) of the Medicare Catastrophic Coverage Act are not applicable to this class of provider.

The third type is a disproportionate share hospital which is an in-state general hospital or a special rehabilitation hospital which has a Medicaid utilization rate equaling or exceeding 1%.

The hospital must have at least 2 obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the state Medicaid plan. The term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. The above obstetric-related criteria do not apply to hospitals in which the inpatients are predominantly individuals under 18 years of age, or to hospitals which do not offer non-emergency obstetric services as of December 21, 1987.

All disproportionate share hospitals must, in addition to the qualifying conditions noted above, have had a Medicaid utilization rate equaling or exceeding 1%. The Medicaid utilization rate shall have been achieved in the base period of December 1994 and shall be computed using the formulas specified in Sec. 1923(b)(2) of the Social Security Act.

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Disproportionate Share - Payment Adjustment

An outlier payment adjustment will be made for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stays for infants who have not attained the age of 1 year, and to children who have not attained the age of six years. When and/or under what conditions this payment is made is as follows:

After thirty days of date of admission, the hospital notified the Medicaid Program regarding a pediatric case(s) which is resource intensive, requires a lengthy stay (in excess of the day outlier threshold or thirty days whichever is longer) and which the DRG rate of payment has been estimated to be less than 65% of charges.

The adjustment payment is the difference between the DRG payment plus normal day outlier payments and 65% of charges.

All hospitals, of this third type shall, in State Fiscal Years beginning after January 1, 1995, receive payment equal to the cost of services furnished to Medicaid patients, less the amount paid under the non-DSH payments under this plan, plus the costs of services provided to patients who have no health insurance or source of third party payments, which would apply to the service for which the individual sought treatment, provided in the hospitals fiscal year ending in the preceding calendar year, less the amount of payments made by these patients. This payment shall be made for services provided in the first quarter of each state fiscal year and shall be paid at a rate of 100% of the above defined costs but shall not exceed a hospital specific maximum payment level of 6% of the gross patient services in the hospital's fiscal year ending in the preceding calendar year.

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Inpatient Hospital Services
Public Process for Determination of Rates

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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